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INCORPORATION BY REFERENCE

Annual Medicaid Home Health/HCB Cost Report
October 1999 Edition

Annual Medicaid Home Health/HCB Cost Report Instructions
October 1999 Edition

Government Auditing Standards
June 1994 Edition

File Date October 27, 1999

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
DIVISION OF LONG TERM CARE
275 EAST MAIN STREET 6W-B
FRANKFORT, KENTUCKY 40621

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT

SCHEDULE S
HOME HEALTH AGENCY COST REPORT INFORMATION AND CERTIFICATION

A. Provider Information

PROVIDER NAME: HHA PROVIDER NO.:

HCB PROVIDER NO.:

Period Covered by Statement: From: To:

Address:

City: State: Zip Code:

Phone Number: Fax Number:

Contact Person: Title:

Phone Number:

B. Type of Control (Check one)

1. Non-Profit:		2. Proprietary:		3. Government:	
Church	_____	Individual	_____	State	_____
Other	_____	Partnership	_____	County	_____
		Corporation	_____	City	_____
				Health Dept.	_____

C. Certification By Officer, Director or Administrator Of The Agency

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER, DIRECTOR OR ADMINISTRATOR OF THE AGENCY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Annual Medicaid Home Health / HCB Cost Report and the Balance Sheet and Statement of Revenue prepared by _____ (Provider name) for the cost report beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____

Officer, Director or Administrator Title Date

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT
SCHEDULE A
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

PROVIDER NAME:

HHA PROVIDER NO.:

HCB PROVIDER NO.:

PERIOD:
From: To:

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPORTATION 3	CONTRACTED SERVICES 4	OTHER 5	TOTAL 6	RECLASSIFICATIONS 7	ADJUSTMENTS 8	NET EXPENSES 9
GENERAL SERVICE COST CENTERS									
1. Capital Related - Bldgs. and Fixtures									
2. Capital Related - Movable Equipment									
3. Plant Operation & Maintenance									
4. Transportation									
5. Administrative and General									
HHA REIMBURSABLE SERVICES									
6. Skilled Nursing Care									
7 Physical Therapy									
8. Occupational Therapy									
9. Speech Therapy									
10. Medical Social Services									
11. Home Health Aide									
12. Medical Supplies									
HCB REIMBURSABLE SERVICES									
13. Client Assessment/Reassessment									
14. Case Management									
15. Homemaker									
16. Personal Care									
17. Respite Care									
18. Home Adaptation									
NONREIMBURSABLE SERVICES									
19. HCB ATTENDANT CARE									
20. HCB MODEL WAIVER #2 (16 HOUR)									
21. Drugs									
22. Durable Medical Equipment									
23. Home Dialysis Aide Services									
24. Respiratory Therapy									
25. Private Duty Nursing									
26. Other:									
27. Other:									
28. TOTAL									

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT
SCHEDULE A - 1
COMPENSATION ANALYSIS - SALARIES AND WAGES

PROVIDER NAME:

HHA PROVIDER NO.:

HCB PROVIDER NO.:

PERIOD:
From: To:

	ADMINISTRATORS 1	DIRECTORS 2	SUPERVISORS 3	NURSES 4	THERAPISTS 5	AIDES 6	ALL OTHER 7	TOTAL 8
GENERAL SERVICE COST CENTERS								
1. Capital Related - Bldgs. and Fixtures								
2. Capital Related - Movable Equipment								
3. Plant Operation & Maintenance								
4. Transportation								
5. Administrative and General								
HHA REIMBURSABLE SERVICES								
6. Skilled Nursing Care								
7 Physical Therapy								
8. Occupational Therapy								
9. Speech Therapy								
10. Medical Social Services								
11. Home Health Aide								
12. Medical Supplies								
HCB REIMBURSABLE SERVICES								
13. Client Assessment/Reassessment								
14. Case Management								
15. Homemaker								
16. Personal Care								
17. Respite Care								
18. Home Adaptation								
NONREIMBURSABLE SERVICES								
19. HCB ATTENDANT CARE								
20. HCB MODEL WAIVER #2 (16 HOUR)								
21. Drugs								
22. Durable Medical Equipment								
23. Home Dialysis Aide Services								
24. Respiratory Therapy								
25. Private Duty Nursing								
26. Other:								
27. Other:								
28. **TOTAL**								

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT
SCHEDULE A - 2
EMPLOYEE BENEFITS ANALYSIS - PAYROLL RELATED

PROVIDER NAME:

HHA PROVIDER NO.:

HCB PROVIDER NO.:

PERIOD:
From: To:

	ADMINISTRATORS 1	DIRECTORS 2	SUPERVISORS 3	NURSES 4	THERAPISTS 5	AIDES 6	ALL OTHER 7	TOTAL 8
GENERAL SERVICE COST CENTERS								
1. Capital Related - Bldgs. and Fixtures								
2. Capital Related - Movable Equipment								
3. Plant Operation & Maintenance								
4. Transportation								
5. Administrative and General								
HHA REIMBURSABLE SERVICES								
6. Skilled Nursing Care								
7 Physical Therapy								
8. Occupational Therapy								
9. Speech Therapy								
10. Medical Social Services								
11. Home Health Aide								
12. Medical Supplies								
HCB REIMBURSABLE SERVICES								
13. Client Assessment/Reassessment								
14. Case Management								
15. Homemaker								
16. Personal Care								
17. Respite Care								
18. Home Adaptation								
NONREIMBURSABLE SERVICES								
19. HCB ATTENDANT CARE								
20. HCB MODEL WAIVER #2 (16 HOUR)								
21. Drugs								
22. Durable Medical Equipment								
23. Home Dialysis Aide Services								
24. Respiratory Therapy								
25. Private Duty Nursing								
26. Other:								
27. Other:								
28. TOTAL								

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT
SCHEDULE A - 3
ANALYSIS OF TRANSPORTATION EXPENSE

HHA PROVIDER NO.:

HCB PROVIDER NO.:

PROVIDER NAME:

PERIOD:
From: To:

	ADMINISTRATORS 1	DIRECTORS 2	SUPERVISORS 3	NURSES 4	THERAPISTS 5	AIDES 6	ALL OTHER 7	TOTAL 8
GENERAL SERVICE COST CENTERS								
1. Capital Related - Bldgs. and Fixtures								
2. Capital Related - Movable Equipment								
3. Plant Operation & Maintenance								
4. Transportation								
5. Administrative and General								
HHA REIMBURSABLE SERVICES								
6. Skilled Nursing Care								
7 Physical Therapy								
8. Occupational Therapy								
9. Speech Therapy								
10. Medical Social Services								
11. Home Health Aide								
12. Medical Supplies								
HCB REIMBURSABLE SERVICES								
13. Client Assessment/Reassessment								
14. Case Management								
15. Homemaker								
16. Personal Care								
17. Respite Care								
18. Home Adaptation								
NONREIMBURSABLE SERVICES								
19. HCB ATTENDANT CARE								
20. HCB MODEL WAIVER #2 (16 HOUR)								
21. Drugs								
22. Durable Medical Equipment								
23. Home Dialysis Aide Services								
24. Respiratory Therapy								
25. Private Duty Nursing								
26. Other:								
27. Other:								
28. **TOTAL**								

ANNUAL MEDICAID
HOME HEALTH / HCB COST REPORT
SCHEDULE A -4

RECLASSIFICATION TO EXPENSE

Provider Name:
Period:
From:
To:

HHA Provider Number:

HCB Provider Number:

	(1) Description	(2) Line #	(3) Increase	(4) <Decrease>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.				
31.				
32.				
33.				
34.				
35.				
36.				
37.				
38.				
39.				
40.				
41.				
42.				
43.				
44.				
45.				
46.				
47.				
48.				
49.				
50.				
51.	TOTAL			

ANNUAL MEDICAID
HOME HEALTH / HCB COST REPORT
SCHEDULE A -5
ADJUSTMENTS TO EXPENSES

Provider Name:

Period:
From:
To:

HHA Provider Number:

HCB Provider Number:

(1) Description	(2) Basis Code	(3) Amount	(4) Line No.
1. Excess funds generated from operations, other than net income	B		
2. Trade, quantity, time and other discounts on purchases	B		
3. Rebates and refunds of expenses.	B		
4. Home Office Costs	A		
5. Adjustments Resulting From 6. Transactions With Related 7. Organizations 8 9. 10. 11. 12.	From Wks A -6		
13. Sale Of Medical Records And Abstracts	B		5
14. Income From Imposition Of Interest, Finance Or Penalty Charges	B		5
15. Sale Of Medical And Surgical Supplies To Other Than Patients	A		12
16. Sale Of Drugs To Other Than Patients	A		21
17. Physical Therapy Adjustment	From Supp Wks A-8-3		7
18. Occupational Therapy Adjustment	From Supp Wks A-8-3		8
19. Speech Therapy Adjustment	From Supp Wks A-8-3		9
20. Interest Expense on Medicare and Medicaid overpayments and borrowings to repay medicare and medicaid overpayments	A		
21. Lobbying Activities	A		
22. Interest Income	B		
23. Owner Compensation Limit	A		
24. Administrator Compensation Limit	A		
25.			
26.			
27.			
28.			
29.			
30.			
31.			
32			
33.			
34. **Total (Sum of lines 1-33)**			

Basis for adjsutment, Column 2.

A. Cost - if cost, including applicable overhead, can be determined
B. Amount Received - If cost cannot be determined

ANNUAL MEDICAID
HOME HEALTH / HCB COST REPORT
SCHEDULE A -6

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

Provider Name: HHA Provider Number:
Period:
From:
To: HCB Provider Number:

A. Are there any costs included on Workseet A which resulted from transactions with related organizations as defined in HCFA Pub. 15-I, chapter 10?

☐ Yes (If "Yes" complete Parts B and C)
☐ No

B. Costs incurred and adjustments required as result of transactions with related organizations:

	Location, item and amount included on Worksheet A, Column 8				Amount Allowable in Cost	Net Adjustments (Col. 4 minus Col. 5)
	Line No.	Cost Center	Expense Items	Amount		
	1	2	3	4	5	6
1						
2.						
3						
4						
5						
6						
7						
8						
9	TOTALS (Sum of lines (1-8) Transfer Col. 6, lines 1-8 to Worksheet A-5, Col 3, lines 5 -12					

C. Interrerelationship of provider to related organization(s):

The Department for Medicaid Services, by virtue of authority granted under KRS XXXXXX, requires the provider to furnish the information requested on Part C of this worksheet.

This information will be used by the Cabinet for Health Services, Department for Medicaid Services, in determining that the costs applicable to services, facilities and supplies furnished by organizations related to the provider by common ownership or control, represent reasonable costs as determined under section 1861 (v)(1) of the Social Security Act and KRS _____. If you do not provide all or any part of the requested information, the cost report will be considered incomplete and not acceptable for purposes of claiming reimbursement under title XIX.

	Symbol (1)	Name	Address	Percent Owned By Provider	Percent Ownership of Provider	Type of Business
1						
2						
3						
4						
5						
6						
7						
8						

(1) Use the following symbols to indicate the interrelationship of the provider to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and provider.
B. Corporation, partnership or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider and related organization.
E. Individual is director, officer, administrator or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial or non financial specify _____

ANNUAL MEDICAID
HOME HEALTH / HCB COST REPORT
SCHEDULE A -7

STATEMENT OF OWNERS, DIRECTORS, AND ADMINISTRATORS COMPENSATION AND STATMENT OF DISCLAIMED COST

Provider Name: HHA Provider Number:
Period:
From:
To: HCB Provider Number:

A. Statement Of Compensation Of Owners

	NAME	TITLE OR FUNCTION	HOURS WEEKLY EMPLOYED AT AGENCY	TOTAL COMPENSATION REPORTED	OWNER COMPENSATION LIMIT	OWNERS COMPENSATION ADJUSTMENT
	1	2	3	4	5	6
1.						
2.						
3.						
4.						
5.						
6.	Total (Sum of lines (1 -5)					

Transfer Col .5, to Schedule A-5, Col 3, line 23. $ -

B. Statement Of Compensation Paid to Administrators or Directors (Other Than Owners)

	NAME	TITLE	PERCENTAGE YEAR EMPLOYED AT AGENCY	TOTAL COMPENSATION REPORTED	ADMINISTRATOR COMPENSATION LIMIT	COMPENSATION ADJUSTMENT
	1	2	3	4	5	6
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.	Total (Sum of lines (1 -5)					

Transfer Col .5, to Schedule A-5, Col 3, line 24. $ -

C. Statement of Disclaimed Cost

The following costs have been deemed unallowable in past cost reports. We disagree with the prior adjustments and have included these costs on this report.

	Description of Cost	Amount	Schedule A, Column and Line
	Col 1	Col 2	Col 3
1.			
2.			
3.			
4.			
5.			

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT

SCHEDULE A-8-3 (1)

Reasonable Cost Determination For Therapy Services Furnished By Outside Suppliers

Provider Name:	HHA Provider No:	Period Beginning:	Period Ending:

CHECK APPLICABLE BOX ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Pathology

Part I - GENERAL INFORMATION

1.	Total number of weeks worked (During which outside suppliers (excluding aides) worked)	
2.	Line 1 multiplied by 15 hours per week	
3.	Number of unduplicated HHA visits - Supervisors or therapists (See Instructions)	
4.	Number of unduplicated HHA visits - Therapy assistants (Include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit) (See Instructions)	
5.	Standard travel expense rate	
6.	Optional travel expense rate per mile	

		Supervisors 1	Therapists 2	Assistants 3	Aides 4
7.	Total hours worked				
8.	AHSEA (See Instructions)				
9.	Standard travel allowance (Cols 1 and 2, one-half of col 2, line 8; col 3 one-half of col 3 , line 8)				
10.	Number of travel hours (HHA only)				
11.	Number of miles driven (HHA only)				

Part II - SALARY EQUIVALENCY COMPUTATIONS

12.	Supervisors (Col 1, line 7 times col 1, line 8)	
13.	Therapists (Col 2, line 7 times col 2, line 8)	
14.	Assistants (Col 3, line 7 times col 3, line 8)	
15.	Subtotal Allowance Amount (Sum of lines 12 - 14)	
16.	Aides (Col 4, line 7 times col 4, line 8)	
17.	Total Allowance Amount (Sum of lines 15 and 16)	
	If the sum of cols 1 - 3, line 7, is greater than line 2, make no entries on lines 18 and 19 and enter on line 20 the amount from line 17. Otherwise, complete lines 18 - 20.	
18.	Weighted average rate excluding aides (Line 15 divided by the sum of cols 1 - 3, line 7)	
19.	Weighted allowance excluding aides (Line 2 times line 18)	
20.	Total Salary Equivalency (Line 17 or sum of lines 16 plus 19)	

Part III - TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - HHA SERVICES

Standard Travel Allowance and Standard Travel Expense

21.	Therapists (Line 3 times column 2, line 9)	
22.	Assistants (Line 4 times column 3, line 9)	
23.	Subtotal (Sum of lines 21 and 22)	
24.	Standard Travel Expense (Line 5 times sum of lines 3 and 4)	

Optional Travel Allowance and Optional Travel Expense

25.	Therapists (Sum cols 1 and 2, line 10 times col 2, line 8)	
26.	Assistants (Col 3, line 10 times Col 3, line 8)	
27.	Subtotal (Sum of lines 30 and 31)	
28.	Optional Travel Expense (Line 6 times sum of cols 1 - 3, line 11)	

Total Travel Allowance and Travel Expense - HHA Services; Complete one of the following three lines 34, 35 or 36, as appropriate.

29.	Standard Travel Allowance and Standard Travel Expense (Sum of lines 23 and 24 - See Instructions)	
30.	Optional Travel Allowance and Standard Travel Expense (Sum of lines 27 and 24 - See Instructions)	
31	Optional Travel Allowance and Optional Travel Expense (Sum of lines 27 and 28 - See Instructions)	

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT

SCHEDULE A-8-3 (2)

Reasonable Cost Determination For Therapy Services Furnished By Outside Suppliers

Provider Name:	HHA Provider No:	Period Beginning:	Period Ending:

CHECK APPLICABLE BOX ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Pathology

Part IV - OVERTIME COMPUTATION

	Description	Therapists	Assistants	Aides	TOTAL
		1	2	3	4
32.	Overtime hours worked during cost reporting period (if col 4, line 32, is zero or equal to or greater than 2,080, do not complete lines 33 - 40 and enter zero in each column of line 41)				
33.	Overtime rate (Multiply the amounts in cols 2 - 4, line 8 (AHSEA) times 1.5)				
34.	Total overtime (Including base and overtime allowance) (Multiply line 32 by line 33)				
	Calculation of Limit				
35.	Percentage of overtime hours by category (Divide the hours in each column on line 37 by the total overtime worked - col. 4, line 37)				
36.	Allocation of provider's standard work year for one full-time employee times the percentages on line 40 (See Instructions)				
	Determination of Overtime Allowance				
37.	Adjusted hourly salary equivalency amount (AHSEA) (From Part II, cols 2 - 4, line 8)				
38.	Overtime cost limitation (Line 41 times line 42)				
39.	Maximum overtime cost (Enter the lesser of line 39 or line 43)				
40.	Portion of overtime already included in hourly computation at the AHSEA (Multiply line 37 by line 42)				
41.	Overtime allowance (Line 44 minus line 45 - if negative enter zero) (Col 4, sum of cols 1 - 3)				

PART V - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

42.	Salary equivalency amount (from Part II, line 20)	
43.	Travel allowance and expense - HHA services (from Part III, lines 29, 30 or 31)	
44.	Overtime allowance (from Part IV, col. 4, line 41)	
45.	Equipment cost (See instructions)	
46.	Supplies (See instructions)	
47.	Total Allowance (Sum of lines 42 - 46)	
48.	Total cost of outside supplier services (from provider records)	
49.	Excess over limitation (line 48 minus line 47 - transfer amount to line A-5,line 17,18, or 19 as applicable - if negative, enter zero --see instructions)	

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT
SCHEDULE B
COST ALLOCATION - GENERAL SERVICE COST

HHA PROVIDER NO.:

HCB PROVIDER NO.:

PROVIDER NAME:

PERIOD:
From: To:

	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0 - 4)	ADMINISTRA-TIVE & GENERAL	TOTAL
		BLDGS & FIXTURES	MOVABLE EQUIPMENT					
	0	1	2	3	4	4A	5	6
GENERAL SERVICE COST CENTERS								
1. Capital Related - Bldgs. and Fixture								
2. Capital Related - Movable Equipment								
3. Plant Operation & Maintenance								
4. Transportation								
5. Administrative and General								
HHA REIMBURSABLE COST CENTERS								
6. Skilled Nursing Care								
7. Physical Therapy								
8. Occupational Therapy								
9. Speech Therapy								
10. Medical Social Services								
11. Home Health Aide								
12. Medical Supplies								
HCB REIMBURSABLE COST CENTERS								
13. Client Assessment/Reassessment								
14. Case Management								
15. Homemaker								
16. Personal Care								
17. Respite Care								
18. Home Adaptation								
NONREIMBURSABLE SERVICES								
19. HCB ATTENDANT CARE WAIVER								
20. HCB MODEL WAIVER #2 (16 HOUR)								
21. Drugs								
22. Durable Medical Equipment								
23. Home Dialysis Aide Service								
24. Respiratory Therapy								
25. Private Duty Nursing								
26. OTHER: _____								
27. OTHER: _____								
28. TOTAL								

ANNUAL MEDICAID HOME HEALTH / HCB COST REPORT
SCHEDULE B -1
COST ALLOCATION - STATISTICAL BASIS

HHA PROVIDER NO.:

HCB PROVIDER NO.:

PERIOD:
From: To:

PROVIDER NAME:

	CAPITAL RELATED COSTS		PLANT OPERATION MAINTENANCE (SQUARE FEET) 3	TRANSPORTATION (MILEAGE) 4	RECONCILIATION 5A	ADMINISTRATIVE & GENERAL (ACCUMULATED COST) 5
	BLDGS & FIXTURES (SQUARE FEET) 1	MOVABLE EQUIPMENT (SQUARE FEET) 2				
GENERAL SERVICE COST CENTERS						
1. Capital Related - Bldgs. and Fixture						
2. Capital Related - Movable Equipment						
3. Plant Operation & Maintenance						
4. Transportation						
5. Administrative and General						
HHA REIMBURSABLE COST CENTERS						
6. Skilled Nursing Care						
7. Physical Therapy						
8. Occupational Therapy						
9. Speech Therapy						
10. Medical Social Services						
11. Home Health Aide						
12. Medical Supplies						
HCB REIMBURSABLE COST CENTERS						
13. Client Assessment/Reassessment						
14. Case Management						
15. Homemaker						
16. Personal Care						
17. Respite Care						
18. Home Adaptation						
NONREIMBURSABLE SERVICES						
19. HCB ATTENDANT CARE WAIVER						
20. HCB MODEL WAIVER #2 (16 HOUR)						
21. Drugs						
22. Durable Medical Equipment						
23. Home Dialysis Aide Service						
24. Respiratory Therapy						
25. Private Duty Nursing						
26. OTHER: _____						
27. OTHER: _____						
28. TOTAL						
29. Cost To Be Allocated (Schedule B)						
30. Unit Cost Multiplier						

ANNUAL MEDICAID HOME HEALTH /HCB COST REPORT
SCHEDULE C
APPORTIONMENT OF HOME HEALTH PATIENT SERVICES

PROVIDER NAME: HHA PROVIDER NO.: PERIOD: From: To:

Part I:

COST PER VISIT COMPUTATION

Patient Services	From Sch B Col. 6, Line:	Total Cost	Total Visits	Average Cost Per Visit	XVIII Cost Limits	XIX Cost Limits	Title XIX Visits	Computation of the lesser of Medicaid Cost or the aggregate of the Medicare or Medicaid limitation: Average	XVIII	XIX
		1	2	3	4	5	6	7	8	9
1. Skilled Nursing	6									
2. Physical Therapy	7									
3. Speech Therapy	8									
4. Occupational Therapy	9									
5. Medical Social Services	10									
6. Home Health Aid Services	11									
7. Total (Sum of Lines 1- 6)										
8. Total Cost (Lesser of Col. 7, 8, 9)										

Part II:

COST PER VISIT COMPUTATION

Patient Services	From Sch B Col. 6, Line:	Total Cost	Total Visits	Average Cost Per Visit	XVIII Cost Limits	XIX Cost Limits	Title XIX Visits	Computation of the lesser of Medicaid Cost or the aggregate of the Medicare or Medicaid limitation: Average	XVIII	XIX
		1	2	3	4	5	6	7	8	9
1. Skilled Nursing	6									
2. Physical Therapy	7									
3. Speech Therapy	8									
4. Occupational Therapy	9									
5. Medical Social Services	10									
6. Home Health Aid Services	11									
7. Total (Sum of Lines 1- 6)										
8. Total Cost (Lesser of Col. 7, 8, 9)										
9. Total XIX Visits (Line 7, Col 8, Part I + Line 7, Col 8, Part II)										

Part III: **MEDICAL SUPPLIES COMPUTATION**

	Cost From Sch. B, Col 6, Ln.	Total Charges From HHA Records	Ratio Col.1 / Col. 2	XIX Charge	XIX Cost
	1	2	3	4	5
1. Medical Supplies					
2. Total Cost Of HHA Services (Part 1, Line 8, Col 9, Part II, Line 8, Col 9, Part III, Line 1, Col 5)					

ANNUAL MEDICAID HOME HEALTH /HCB COST REPORT

SCHEDULE D

CALCULATION OF HOME HEALTH REIMBURSEMENT SETTLEMENT

PROVIDER NAME:

HHA PROVIDER NO.:

PERIOD:
From: To:

Part I - Computation Of The Lesser Of Reasonable Cost Or Customary Charges

1. Cost Of Services (From Schedule C, Part III, Line 2) _____
2. Total Charges For Title XIX Services (From PCL's) _____
3. Excess Of Reasonable Cost Over Customary Charges (Complete Only If Line 1 Exceeds Line 2) _____

Part II Computation Of Reimbursement Settlement

4. Total Reasonable Cost (From Line 1) _____
5. Excess Reasonable Cost (From Line 3) _____
6. Subtotal (Line 4 Minus Line 5) _____
7. Amounts Rec'd From TPL/Other Sources (PCL's) _____
8. Amounts Rec'd From The Medicaid Program (PCL's) _____
9. Amount Received As Incentive Payments (PCL's) _____
10. Total Interim Payments (Line 7 plus 8 minus 9) _____
11. Balance Due Provider/Medicaid Program (Line 6 minus 10) (Indicate Overpayments In Parentheses) _____

ANNUAL MEDICAID HOME HEALTH /HCB COST REPORT
SCHEDULE E
APPORTIONMENT OF PATIENT HCB SERVICE COSTS AND CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NAME: HCB PROVIDER NO.: PERIOD: From: To:

Patient Service	Amounts (Sch B Col 7)	Total Units/Visits	Average Cost Per Unit/Visit	XIX Cost Limits	XIX Unit/Visits	Cost of Service Average	Cost of Service XIX
1	2	3	4	5	6	7	8
Part I Visits before 7/1							
1. Client Assessment							-
2. Case Management							
3. Homemaker							
4. Personal Care							
5. TOTAL (Sum of lines 1 - 4)			XXXXXXXX	XXXXXXXXX			
6. Allowable Costs Of Patient Services (Lesser of Line 5, Column 7 or Column 8)							
Part II Visits after 7/1							
7. Client Assessment							
8. Case Management							
9. Homemaker							
10. Personal Care							
11. TOTAL (Sum of Lines 7 - 10)			XXXXXXXX	XXXXXXXXX			
12. Allowable Costs Of Patient Services (Lesser of Line 11, Column 7 or Column 8)					XXXXXXXXX		
13. Total Visits (Line 5 plus Line 11, Column 6)							

Part III Respite and Minor Home Adaptation Costs	Costs	Charges	Lesser Of
14. Total Allowable Costs/Charges For Respite Care Services			
15. Total Allowable Costs/Charges For Minor Home Adaptation Services			

Part IV Calculation Of Reimbursement Settlement	
16. Reimbursable Costs (Sum of Column 8, Line 6 and Line 12)	
17. Total Charges For Waiver Program Services From PCL's (Less Respite & Home Adaptation)	
18. Reimbursable Cost (Lesser of Lines 16 or 17)	
19. Respite And Minor Home Adaptation (Line 14 plus Line 15)	
20. Total Medicaid Cost (Line 18 plus Line 19)	
21. Amount Received From Medicaid For Waiver Program Services	XXXXXXXXXX
22. Continuing Income Or TPL	XXXXXXXXXX
23. Balance Due (Program)/Provider (Line 20 minus Lines 21 and 22)	

INTRODUCTION

These instructions are intended to guide providers in preparing the annual cost report. These forms shall be used by all participating home health agencies. Some schedules shall not be required for all providers and these need not be completed. However, the entire cost report shall be submitted to Medicaid Services. Schedules, which do not apply, shall be marked accordingly, and brief explanation as to why these are not needed shall be annotated on appropriate schedules.

In completing the schedules, the period beginning and period ending, the provider name, Medicaid identification number and address shall be indicated on the cover page. In addition, the provider name and inclusive dates covered by this cost report shall be indicated on each page. Facilities shall submit a cost report prepared on the accrual basis of accounting principles. Also, in completing the schedules, reductions to expenses shall always be shown in brackets.

The Trial Balance of the agency shall be included with the submission of the Annual HHA/ HCB Medicaid Annual Cost Report.

SCHEDULE S - HOME HEALTH AGENCY COST REPORT INFORMATION STATISTICAL AND CERTIFICATION

A. Provider Information.

Home Health Agency Information -- Enter the requested information in the space provided. Include the name of the agency, the Medicaid identification numbers, phone and fax numbers, contact person and title. Enter the beginning and ending dates of the period covered by this cost report.

B. Type of Control- Check the appropriate line for items 1 through 3.

1. Non-Profit Indicate by checking appropriate line - Church or Other.

2. Proprietary Organization - Check if the Home Health Agency is owned and operated by an individual or a business corporation. The organization may be a sole proprietorship, partnership (including limited partnership and joint stock company) or corporation.

3. Official (Governmental Agency) - Check if the Home Health Agency is administered by a state, county, city, or health department. Indicate the type of official agency by checking the appropriate line.

C. Certification by Officer, Director or Administrator of the Agency.

This form shall be read and signed by an officer or director of the Home Health Agency. Sections 1877(a) (1) of the Social Security Act state that, "Whoever knowingly and willfully makes or causes to be made any false statement or representation of material fact in any application for any benefit or payment under this title--shall (1) in the case of such a statement, representation, concealment, failure or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five (5) years, or both, or in the case of such statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one (1) year or both."

SCHEDULE A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

This schedule provides for recording of direct costs such as salaries, fringe benefits, transportation and contracted services, as well as other costs to arrive to identifiable agency costs in Column 9. Also, it provides for the reclassification and adjustments to certain accounts. The total direct expenses before grouping, reclassifications and adjustments are obtained form the provider' s records.

The cost centers on this schedule are listed in a manner which facilitates the sequential listing of accounts and array of expense accounts for transfer of the various cost center data from Schedules A-1, A-2, A-3.

The costs to be entered in Columns 1 through 5 are only those actual costs incurred by or for the Home Health Agency for which the cost report is prepared. If true reporting entity is a certified "sub unit" of a State Health Department, the amounts to be entered shall be only those amounts that are directly applicable to the "sub unit." The aggregation and reallocation of costs at the state level shall not be acceptable.

Column 1 — SALARIES.-- The expenses listed in this column obtained from Worksheet A-1. The sum of column 1 must equal Worksheet A-1, column 9 line 29.

Column 2: — EMPLOYEE BENEFITS.-- The expenses listed in this column are obtained from Worksheet A-2. The sum of column 2 must equal Worksheet A-2, column 9, line 29.

Column 3: — TRANSPORTATION.-- Enter on each line other than line 4 the cost of public transportation or the amount paid to employees for the use of private vehicles only when these costs can be identified and directly assigned to a particular cost center.

Where the agency owns (or rents its vehicles, this cost should be entered on line 4 in the transportation cost center and allocated during the cost finding process.

The transportation cost is reported in this manner so that the identifiable costs can be recorded where applicable and the

unidentifiable costs will be allocated during cost finding.

Column 4: CONTRACTED/PURCHASED SERVICES.-- The expenses listed in this column are obtained from Schedule A-3. The sum of column 4 must equal Schedule A-3 , column 9, line 29.

Column 5: OTHER COSTS.-- Enter on the applicable lines in column 5 all agency costs which have not been reported in columns 1 through 4 from the agency's books and records.

Column 6: Total Agency Cost.--Add the amounts in columns 1 through 5 for each cost center and enter the totals in column 6.

Column 7: RECLASSIFICATIONS OF EXPENSE.--Enter in this column any reclassifications among the cost center expenses in column 6, which are needed to amend expenses appropriate in the particular agency's circumstances. Reductions to expense should be shown in parentheses ( ). The reclassification of expenses in this column is the net total of the entries obtained from Schedule A-4. The total of this column shall equal zero.

Column 8: ADJUSTMENTS TO EXPENSE.--Enter in this column any adjustments to the expenses in column 6, which are needed to amend expenses appropriate to a particular agency's circumstances to comply with applicable state and federal law and regulations. These expenses shall be obtained from Schedule A-5. The total of this column shall be equal to of Schedule A-5 column 3, line 36.

Column 9: Enter the Sum of Columns 6, 7, and 8.

SCHEDULE A-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

The expenses on this schedule shall be those amount paid or accrued on the records of the provider. These amounts shall be those expenses for which a Federal Form W-2 was issued to the employee.

Column 1: Enter amounts for administrators. If a single administrator this amount shall be entered on line 5.

Column 2: Enter amounts for directors.

Column 3: Enter amounts for supervisors.

Column 4: Enter amounts for Licensed Registered Nurses.

Column 5: Enter amounts for Licensed Therapists and Licensed Therapy Assistants.

Column 6: Enter amounts for Aides.

Column 7: Enter amounts for all others not included in columns 1 through 6.

Column 8: Enter the total of each line for columns 1 through 7. Enter these amounts on the corresponding lines on Schedule A, Column 1.

SCHEDULE A-2 - EMPLOYEE BENEFITS ANALYSIS - PAYROLL RELATED

The employee benefits expense on this schedule shall be those amount paid or accrued on the records of the provider. These amounts shall be those expenses, which directly correspond to the employees as listed on Schedule A-1.

Column 1:	Enter amounts for administrators. If a single administrator this amount shall be entered on line 5.
Column 2:	Enter amounts for directors.
Column 3:	Enter amounts for supervisors.
Column 4:	Enter amounts for Licensed Registered Nurses.
Column 5:	Enter amounts for Licensed Therapists and Licensed Therapy Assistants.
Column 6:	Enter amounts for Aides.
Column 7:	Enter amounts for all others not included in columns 1 through 6.
Column 8:	Enter the total of each line for columns 1 through 7. Enter these amounts on the corresponding lines on Schedule A, Column 2.

SCHEDULE A-3 - TRANSPORTATION

The transportation expense on this schedule shall be those amount paid or accrued on the records of the provider. These amounts shall be those expenses, which directly correspond to the employees as listed on Schedule A-1

Column 1: Enter amounts for administrators. If a single administrator this amount shall be entered on line 5.

Column 2: Enter amounts for directors.

Column 3: Enter amounts for supervisors.

Column 4: Enter amounts for Licensed Registered Nurses.

Column 5: Enter amounts for Licensed Therapists and Licensed Therapy Assistants.

Column 6: Enter amounts for Aides.

Column 7: Enter amounts for all others not included in columns 1 through 6.

Column 8: Enter the total of each line for columns 1 through 7. Enter these amounts on the corresponding lines on Schedule A, Column 2.

SCHEDULE A-4 — RECLASSIFICATIONS TO EXPENSE

This schedule provides for the reclassification of expense accounts to effect proper cost allocation under cost finding. The following are examples of costs, which shall be reclassified:

A. Licenses and Taxes (Other Than Income Taxes) – This expense consists of the business license expense and tax expense incidental to the operation of the agency. These expenses shall be included in the Administrative and General (A & G) cost centers, Schedule A, line 5.

B. Interest - Short-term interest expense relates to borrowings for agency operations. The full amount of this cost shall be reclassified to Administrative and General, Schedule A, line 5.

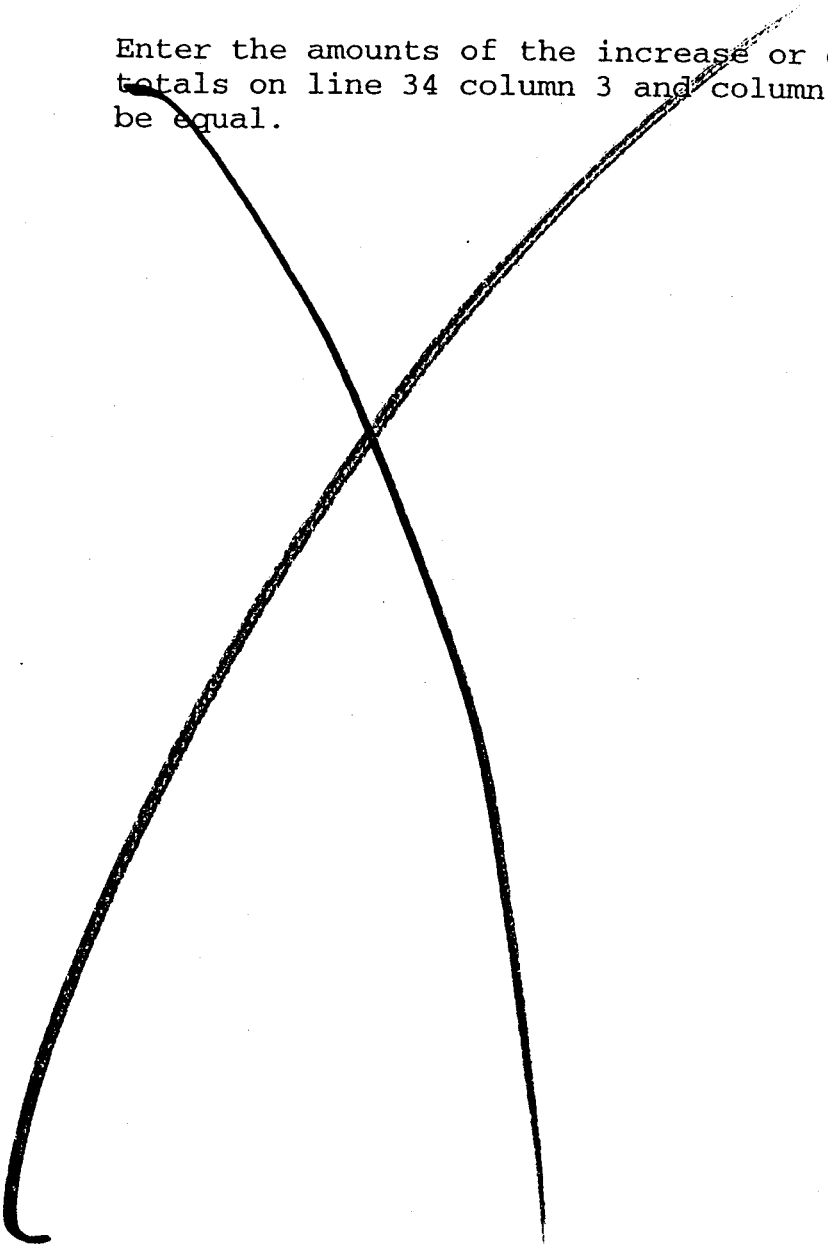
C. Insurance - Malpractice, Insurance and Other -Reclassify these insurance expenses to Administrative and General, Schedule A, line 5. Malpractice insurance may be reclassified directly to the applicable cost centers (other than A & G) only if the insurance policy specifically and separately identifies the premium for each cost center involved.

D. If a provider purchases services (e.g., physical therapy) under arrangements for Medicaid patients, but does not purchase the services under arrangements for non-Medicaid patients, the providers' books shall reflect only the cost of the Medicaid services. However, if the provider does not use the "grossing up" technique for purposes of allocating overhead, and incurs related direct costs applicable to all patients, Medicaid and non-Medicaid (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), the related costs shall be reclassified from the Home Health Agency reimbursable service cost center and allocated as part of administrative and general expense.

E. Leases - This expense consists of all rental costs of buildings and equipment incidental to the operation of the Home Health Agency. Any lease which cannot be identified to a special cost center and is incidental to the general overall operation of the agency shall be included in Administrative and General, Schedule A, line 5.

F. The cost of medical supplies purchased during the applicable cost reporting years and remaining in inventory should be reclassified from Schedule A. Line 12 to Line 5.

Column 1:	Indicate the description of item to be reclassified on lines 1 through 33.
Column 2:	Indicate line number from Schedule B where reclassification is entered.
Column 3 and 4:	Enter the amounts of the increase or decrease. totals on line 34 column 3 and column 4 shall be equal.



SCHEDULE A-5 - ADJUSTMENTS TO EXPENSE

This schedule provides for the adjustments to the expense listed on Schedule A, Column 8. These adjustments shall be made on the basis of "cost" or revenue received" as indicated by the symbols entered in Column 2 "A" for cost or "B" for revenue received. Line descriptions indicate the more common activities, which affect allowable cost, or result in costs incurred for reasons other than patient care and, thus, requires adjustments. Use this schedule to enter any adjustments to expenses that are the result of differences between regulations and the records of the provider.

If an adjustment to an expense affects more than one (1) cost center, the adjustments to expense shall reflect the adjustment to each cost center on a separate line on Schedule A-5.

Types of items to be entered on Schedule A-5 shall be: (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, grants, gifts, etc.; (3) those items needed to adjust expenses in accordance with Medicaid principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process. Hospital-based facilities shall adjust their cost on this schedule to agree with cost on HCFA Form 2552, Worksheet H-5,Column 6.

Column 1	Line Descriptions:
Line 1	Excess funds generated from operations, other than net income.
Line 2	Trade, Quantity, Time and Other Discounts on Purchases
Line 3	Rebates and Refunds of Expenses
Line 4	Home Office Costs - Enter on this line allowable home office cost which have been allocated to the provider. If home office costs are submitted, provider shall submit a copy of the home office cost report.
Line 5 - 12	Adjustments Resulting from Transactions with Related Organizations - The amount to be entered on this line shall be obtained from Schedule A-6, Part B, Column 6.
Line 13	Sale of Medical Records and Abstracts - Enter the amount received from the sale of medical

records and abstracts and offset the amount against the Administrative and General costs.

Line 14 — Income from Imposition of Interest, Finance or Penalty Charges - Enter on this line the cash received imposition of interest, finance or penalty charges on overdue receivables. This income shall be used to offset the allowable Administrative and General costs.

Line 15 — Sale of Medical and Surgical Supplies to Other than Patients. This income shall be used to offset the allowable Medical Supply cost.

Line 16 — Sale of Drugs to Other than Patients this income shall be used to offset the allowable cost of drugs.

Line 17 — Physical Therapy Adjustment - If Home Health Agency purchases physical therapy services furnished by an outside supplier, schedules A-8-3(1) and A-8-3(2) shall be completed to compute the reasonable cost determination. Enter on this line any adjustment (Excess cost over Limitations) from Schedule A-8-3(2), Part V, line 49. Enter this amount as a negative number.

Line 18 — Occupational Therapy Adjustment - If Home Health Agency purchases occupational therapy services furnished by an outside supplier; Schedules A-8-3(1) and A-8-3(2) shall be completed to compute the reasonable cost determination. Enter on this line any adjustment (Excess cost over Limitations) from Schedule A-8-3(2), Part V, line 49. Enter this amount as a negative number.

Line 19 — Speech Therapy Adjustment - If Home Health Agency purchases speech therapy services furnished by an outside supplier; Schedules A-8-3(1) and A-8-3(2) shall be completed to compute the reasonable cost determination. Enter on this line any adjustment (Excess cost over Limitations) from Schedule A-8-3(2), Part V, line 49. Enter this amount as a negative number.

Line 20 — Interest Expense on Borrowing to Repay Medicaid Overpayments

Line 21 — Lobbying Activities. These shall include costs incurred directly and/or the proportionate share

incurred by an organization of which the provider is a member reflected in dues assessments.

Line 22 — Offset of Investment Income

Line 23 — Owner Compensation Limit. Adjustments Resulting from limits imposed by regulation on the compensation allowable as cost borne by the program. Owner's Compensation Adjustment - The amount to be entered on this line shall be obtained from Schedule A-7, Part A, Column 5.

Line 24 — Administrator Compensation Limit. Adjustments Resulting from limits imposed by regulation on the compensation allowable as cost borne by the program. Administrator Compensation Adjustment - The amount to be entered on this line shall be obtained from Schedule A-7, Part B, Column 5.

Line 25-33 — Enter on these lines any additional adjustments, which are required which affect proper cost allocation of expenses. The lines shall be appropriately labeled to indicate the nature of the required adjustments.

Column 2: — On each line enter an "A" if the amount in Column 3 is actual cost or a "B" if the amount in Column 3 is the revenue received for the item in Column 1.

Column 3: — On each line indicate the amount to be adjusted.

Column 4: — Indicate the line number on Schedule A that is to be adjusted.

SCHEDULE A-6 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

A. Section A is provided to show whether the amount of costs to be reimbursed by the Medicaid Program includes costs resulting from services, facilities, and supplies furnished to the facility by organizations related to the facility by common ownership or control. Section A shall be completed by all facilities.

B. Section B is provided to show the total compensation paid for the period for sole proprietors, partners, and corporation officers, as owner(s) of the Home Health Agency. Compensation shall be defined as the total benefit received (or receivable) by the owner for the services he provides to the institution. It shall include salary amount paid for managerial, administrative, professional and other services; amounts paid by the agency for the personal benefit of the owner; and the cost of the assets and services, which the owner receives, form the agency and deferred compensation.

C. Section C is provided to show total compensation paid to each employed person(s) to perform duties as administrators or assistant administrators. List: each administrator or assistant administrator who has been employed during the fiscal period. List the name, title, percent of customary workweek devoted to business, percent of the fiscal period employed, and total compensation for the period.

SCHEDULE A-7 - STATEMENT OF OWNERS, DIRECTORS, AND ADMINISTRATORS COMPENSATION AND STATEMENT OF DISCLAIMED COST

This schedule provides for the determination of allowable compensation of owners as limited by regulation.

Section A:

Column 1: List Name of owner as defined by KAR _____.

Column 2: List Title and Function of owner.

Column 3: List the number of hours weekly employed at the Agency.

Column 4: Enter the amount of compensation reported on Schedule A. This should include all amounts received or accrued, and amounts employee benefits in excess of those provided to all employees.

Column 5: Enter the amount of reported compensation that exceeds the limit as published by Kentucky Administrative Regulation. Transfer these amounts to Schedule A-5, Col. 1, line 23.

Section B: Statement of Compensation Paid to Administrators or Directors (Other Than Owners)

This schedule provides for the determination of allowable compensation of administrators and directors (other than Owners) as limited by regulation.

Column 1: List Name of the administrator or director.

Column 2: List Title and Function of Administrator or Director

Column 3: List the percentage of year employed at the Agency.

Column 4: Enter the amount of compensation reported on Schedule A. This should include all amounts received or accrued, and amounts

employee benefits in excess of those provided to all employees.

Column 5: Enter the amount of reported compensation that exceeds the limit as published by Kentucky Administrative Regulation. Transfer these amounts to Schedule A-5, Col. 3, line 24.

Section C: Statement of Disclaimed Cost

This schedule provides for the disclosure of cost deemed unallowable in a past cost report included in allowable cost on this report regulation.

Column 1: Enter a description of the cost deemed unallowable in a prior report included on this report.

Column 2: Enter the amount of the included cost.

Column 3: Enter the Schedule A, Column and Line where the cost was included.

Schedule A-8-3 (1) - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Information required on this schedule provides, in the aggregate, all data for therapy services either physical therapy, occupational therapy and/or speech pathology services furnished by all outside suppliers in determining the reasonableness of therapy costs. (See HCFA Pub.15-I, chapter 14.) (See 42 CFR §413.106.)

Complete this schedule once for each type of therapy service furnished by an outside supplier.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depends on several factors:

- An initial test to determine whether these services are categorized as intermittent part time or full time services;
- The location where the services are rendered, i.e., HHA home visit;
- For HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;
- Add-ons for supervisory functions, aides, overtime, equipment, and supplies; and
- Intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

Part I - GENERAL INFORMATION

This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1--For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. (See HCFA Pub. 15-I, chapter 14.)

Line 2--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full time or intermittent part time.

Line 3--Enter the number of unduplicated HHA visits made by the supervisor or therapist. Only count one visit when both the supervisor and therapist were present during the same visit.

Line 4--Enter the number of unduplicated HHA visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist were present during the same visit.

Line 5--Enter the standard travel expense rate applicable. (See HCFA Pub. 15-I, chapter 14.)

Line 6--Enter the optional travel expense rate applicable. (See HCFA Pub. 15-I, chapter 14.) Use this rate only for home health patient services for which time records are available.

Line 7--Enter in the appropriate columns the total number of hours worked for therapy supervisors, therapists, therapy assistants, and aides furnished by outside suppliers.

Line 8--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in HCFA Pub. 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of HCFA Pub. 15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of HCFA Pub. 15-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, and aides respectively) the AHSEA from either the appropriate exhibit found in HCFA Pub. 15-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See HCFA Pub. 15-I, §1412.2.)

Line 9--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 8. Enter in column 3 one half of the amount in column 3, line 8. (See HCFA Pub. 15-I, §1402.4.)

Lines 10 and 11--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See HCFA Pub. 15-I, §§1402.5 and 1412.6.)

NOTE: There is no travel allowance for aides employed by outside suppliers.

Part II - SALARY EQUIVALENCY COMPUTATIONS

This part provides for the computation of the full time or intermittent part time salary equivalency.

When you furnish therapy services from outside suppliers to Medicaid patients but simply arrange for such services for non health care program patients and do not pay the other Medicaid portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of HCFA Pub. 15-I, §2314, complete Part II, lines 12 through 17 and 20 in all cases and lines 18 and 19, where appropriate. However, where you cannot gross up costs and charges, complete lines 12 through 17 and 20.

Lines 12 through 17--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 7) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, and aides.

Lines 18 and 19--If the sum of hours in columns 1 through 3, line 7, is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 20--If there are no entries on lines 18 and 19, enter the amount on line 17. Otherwise, enter the sum of the amounts on lines 16 and 19.

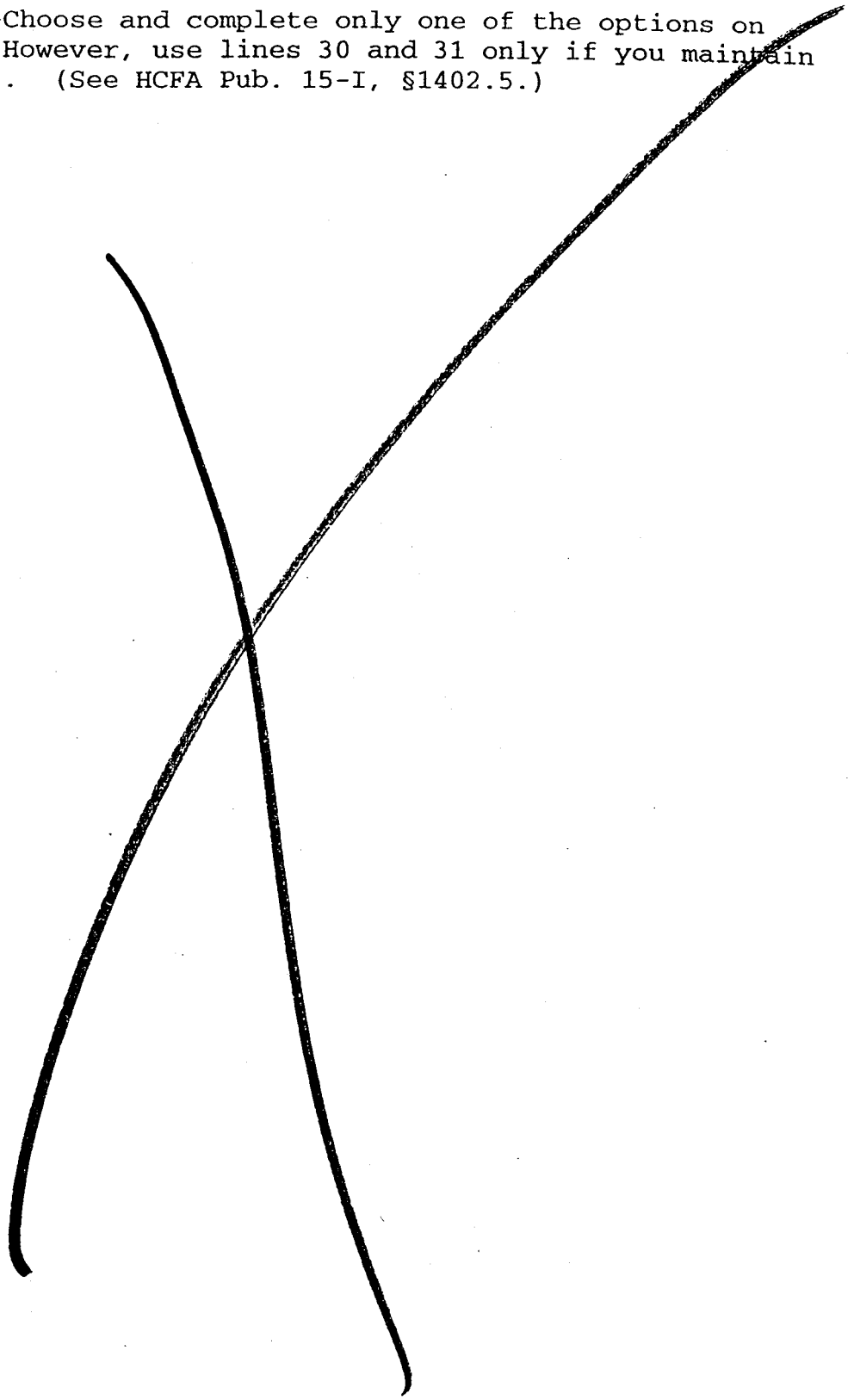
Part III - TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - HHA SERVICES

This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See HCFA Pub. 15-I, §§1402ff, 1403.1 and 1412.6.)

Lines 21 through 24--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with HHA visits. Use these lines only if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 25 through 28--Complete the optional travel allowance and optional travel expense computations for therapy services in conjunction with home health services only. Compute the optional travel allowance on lines 25 through 27. Compute the optional travel expense on line 28.

Lines 29 through 31--Choose and complete only one of the options on lines 29 through 31. However, use lines 30 and 31 only if you maintain time records of visits. (See HCFA Pub. 15-I, §1402.5.)



Schedule A-8-3 (2)--REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Part IV: OVERTIME COMPUTATION

This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See HCFA Pub. 15-I, §1412.4.)

Line 32--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 4 are either zero or equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 33 through 40. Enter zero in each column of line 41. Enter the sum of the hours recorded in columns 1 through 3 in column 4.

Line 33--Enter in the appropriate column the overtime rate (the AHSEA from line 8, column as appropriate, multiplied by 1.5).

Line 35--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 32 by the total overtime hours in column 4, line 32.

Line 36--Use this line to allocate your standard work year for one full time employee. Enter the numbers of hours in your standard work year for one full time employee in column 4. Multiply the standard work year in column 4 by the percentage on line 35 and enter the result in the corresponding columns.

Line 37--Enter in columns 1 through 3 the AHSEA from Part I, line 10, columns 2 through 4, as appropriate.

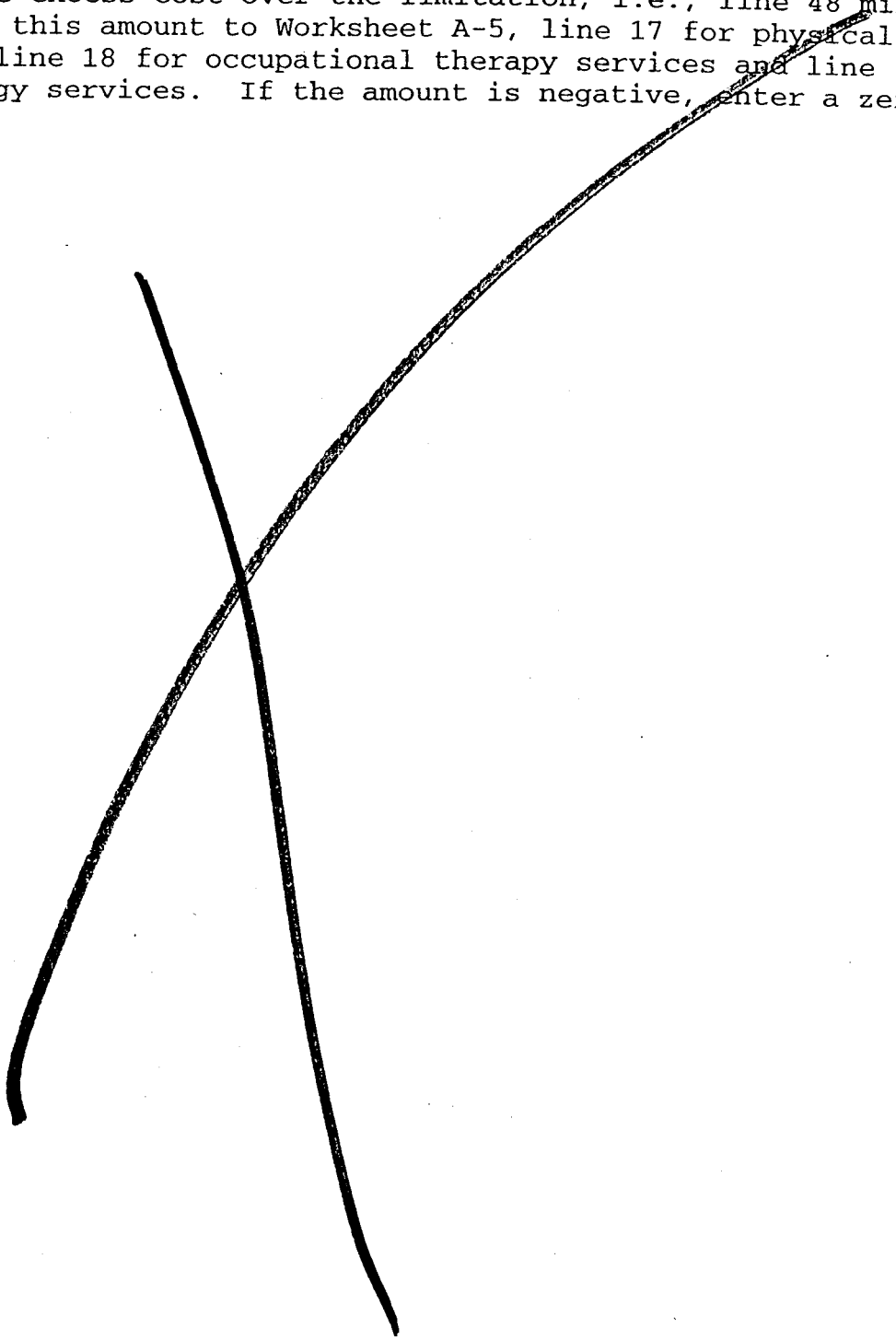
Part V - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

This part provides for the calculation of the adjustment to therapy service costs in determining the reasonableness of therapy cost.

Lines 45 and 46--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier (as specified in HCFA Pub. 15-I, §1412.1) is considered an additional allowance in computing the limitation.

Line 48--Enter the amounts paid and/or payable to the outside suppliers for therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expenses related to supplying therapy services for you.

Line 49--Enter the excess cost over the limitation, i.e., line 48 minus line 47. Transfer this amount to Worksheet A-5, line 17 for physical therapy services, line 18 for occupational therapy services and line 19 for speech pathology services. If the amount is negative, enter a zero.



SCHEDULE B - COST ALLOCATION - GENERAL SERVICE COST

Schedule B in conjunction with Schedule B-1 provide for simplified cost finding. The simplified cost-finding methodology provides for allocating general service (overhead) costs directly to revenue producing and non-reimbursable cost centers.

Column 1: Enter the direct costs associated with the services listed on lines 17 through 33, Column 5, Schedule B.

Column 2, 3, and 4: Multiply the unit cost multiplier on Schedule C by the detail on Schedule C. The products shall be entered on the corresponding lines on C-1.

Column 5: The sum of Columns 1, 2, 3, and 4.

Column 6: Multiply the unit cost multiplier on Schedule C, Column 4, by the detail on Schedule C, Column 4.

Column 7: Enter sum of lines 5 and 6 for each service area and transfer amounts in Column 7, lines 17 through 23, before and after, to Schedule D, Column 2, and Column 7, Lines 24 through 27, before and after, to Schedule E, Column 2.

Column 7: Line 28 and 29 to Schedule E, Part III, column 6, line 14 and 15.

SCHEDULE B-1 - COST ALLOCATION - STATISTICAL BASIS

Schedule B-1: This schedule shall be used to provide the statistics necessary for the allocation of general services costs among the service areas on Schedule B.

Column 1: Enter in Column 1, the total square feet of the building and fixtures applicable to the cost center to which depreciation shall be allocated on Lines 17 through 33.

Line 34 shall be the total of lines 17 through 33.

Line 35 shall be the total of Line 1, 3, 4, 10, 11, and 14, Column 6, Schedule B.

Line 36, divide line 35 by line 34 and enter the amount oil line 36.

Column 2: Enter in column 2, the mileage for each service area on Lines 17 through 33.

Line 34 shall be the total lines 17 through 33.

Line 35 shall be the total of lines 2, 5, and 13, Column 6, Schedule B.

Line 36, divide line 35 by line 34 and enter the amount on line 36.

Column 3: Enter in Column 3 the gross salaries paid to employees in each service area on Lines 18 through 33.

Line 34 is the total of lines 17 though 33.

Line 35 is the total of line 7, Column 6, Schedule B.

Line 36, divide line 35 by line 34 and enter the amount on line 36.

Column 4: Enter in Column 4, accumulated costs on lines 17 through 33, Column 5, Schedule C-i.

Line 34 is the total of lines 17 through 33, Column 4. Line 35 is the total of lines 6, 8, 9, 12, 15, and 16, Schedule B.

Line 36, divide line 35 by line 34; enter the resulting unit cost multiplier on line 36.

SCHEDULE C - APPORTIONMENT OF HOME HEALTH PATIENT SERVICES

This schedule provides for the apportionment of Home Health patient service costs to Medicaid Services only. In addition, this schedule provides for the application of Medicare and Medicaid cost limitations, if applicable, to each Home Health Agency's total allowable cost in determining the Medicaid reimbursable cost.

The computation of Medicaid reimbursable cost shall be determined by utilizing the lower of the average cost per visit, Medicare cost limits, or Medicaid cost limits compared on an aggregate basis.

Column 2 - Amounts - Enter in column 2 the amount for each discipline from Schedule C-1, column. , lines as indicated in Column 1.

Column 3 - Enter the total agency visits from statistical data Schedule A, Column 1, for each type of discipline on lines 1 through 6.

Column 4 - This is the average cost per visit for each type of discipline. Divide the cost (column 2) by number of visits (column 3) for each discipline.

Column 5 - Enter Medicare cost limits from the Medicare notification letter for each discipline, lines 1 through 6.

Column 6 - Enter Medicaid cost limits as specified in the appropriate reimbursement letter for each discipline, lines 1 through 6, if applicable.

Column 8 - Enter Medicaid Program Visits for each discipline, lines 1 through 6.

Column 9 - Multiply the average cost per visit (column 4) by the Medicaid visits (column 8) for each discipline, lines 1 through 6 and enter the product in column 9.

Column 10 - Multiply the Medicare cost limits (column 5) by the Medicaid visits (column 8) for each discipline, lines 1 through 6 and enter the product in column 10.

Column 11 - Multiply the Medicaid cost limits (column 6) by the Medicaid visits (column 8) for each discipline, lines 1 through 6 and enter the product in column 11.

Line 7 Sum of lines 1 through 6 for appropriate column.

Line 8 Enter the lesser of column 9, column 10, or column 11, line 7.

Part II - Cost Per Visit Computation (for visits with service dates on or after 7/1)

See instructions for Part 1, columns 2 through 1.

Line 8 Enter the lesser of column 9, column 10, or column 11, line 7.

Line 9 Enter the total visits from Part I, line 7, Column 8 and Part II, line 7, Column 8.

PART III - Medical Supplies Computation

Column 1 Enter cost from line 17, column 7, Schedule C-1.

Column 2 Enter total charges from facility records.

Column 3 Divide amount in column 1 by amount in column 2.

Column 4 Enter Medicaid charges, column 5, Line 1, Multiply ratio in column 3 b amount in column 4.

Column 5 Multiply ratio in column 3 by amount in column 4.

Column 5, Line 2 Add amount in column 11, line 8, Part 1, column 11, line 8, Part II, and column 5, line 1, Part III.

Schedule D - Calculation of Reimbursement Settlement

Part I, Computation of the Lesser of Reasonable Cost or Customary Charges

Line 1 Cost of services from Schedule D, Part III, line 2, column 5.

Line 2 Amount of Medicaid charges.

Line 3. If line 1 is greater than line 2, enter the excess cost on line 3, if applicable.

Part II, Computation of Reimbursement Settlement

Line 4 Enter total reasonable cost from line 1.

Line 5 Enter excess reasonable cost from line 3, if applicable.

Line 6 Subtract lines 5 from line 4.

Line 7 Enter amounts received from third party payors.

Line 8 Enter amounts received from the Medicaid Program.

Line 9 Enter incentive payment (determined by utilizing data from the applicable Medicaid Paid Claims Listings and rate notices issued to provider on July 1.)

Line 10 Enter total interim payments (lines 7+8-9)

Line 11 Enter balance due Provider or Medicaid Program (line 6-10) . Indicate overpayments in parentheses ( ).

Schedule E - Apportionment of HCB Patient Service Costs and Calculation of Reimbursement Settlement

Part I, Cost Per Visit Computation (for Visits with service dates prior to July 1)

Column 2 - Enter amount in Column 2 from Schedule C-1, Column 7, for each discipline in Column 1.

Column 3 - Enter in Column 3, lines 1 through 4 total units\visits from Schedule A, Column 1, lines 7-10, for each discipline.

Column 4 - Compute the average cost per visit for each type of discipline. Divide the number of visits (Column 3) into the cost (Column 2 for each discipline of service on lines 1 through 4.

Column 5 - Enter the Medicaid Cost Limits per discipline. (The Department for Medicaid Services shall furnish the limits to the HHA effective July 1 of each year.)

Column 6 - Enter the Title XIX units\visits from the Medicaid Paid Claims Listings on lines 1 through 4.

Column 7 - Multiple the average cost per visit (column 4) by the Title XIX Visits (Column 6) for each discipline, lines 1 through 4 and enter the product in Column 7.

Column 8 - Multiple the Title XIX Cost Limits (column 5) by the Title XIX Visits (Column 6) for each discipline, lines 1 through 4 and enter the product in Column 8.

Part II - Cost Per Visit Computation (for visits with service dates after July 1)

Column 2 - Enter amount in Column 2 from Schedule C-1, Column 7, for each discipline as indicated in Column 1.

Column 3 - Enter in Column 3, lines 7 through 10 total units\visits from Schedule A, Column 1, lines 7-10 for each discipline.

Column 4 - Compute the average cost per visit for each type of discipline. Divide the number of visits (Column 3) into the cost (Column 2) for each discipline of service on lines 7 through 10.

Column 5 - Medicaid Cost Limits - Enter the Medicaid Cost Limits per discipline as indicated or average cost.

Column 6 - Enter the Title XIX units\visits from the Medicaid Paid Claims Listings on lines 7 through 10.

Column 7 - Multiple the average cost per visit (column 4) by the Title XIX Visits (Column 6) for each discipline, lines 7 through 10 and enter the product in Column 7.

Column 8 - Multiple the Title XIX Cost Limits (Column 5) by the Title XIX Visits (Column 6) lines 7 through 10 and enter the produce in Column 8.

Part III - Respite Care and Minor Home Adaptation Calculation

Line 14, Column 6 - Enter allowable cost for Respite Care from Schedule C-1, Line 28, Column 7.

Line 14, Column 7 - Enter Respite Care Charges from Medicaid Paid Claim Listings.

Line 14, Column 8 - Enter lesser of Line 14, Column 6 or Column 7.

Line 15, Column 6 - Enter allowable cost for Minor Home Adaptation from Schedule C-1, Line 29, Column 7.

Line 15, Column 7 - Enter Minor Home Adaptation Charges from Medicaid Paid Claims Listings. Line 15, Column 8 - Enter lesser of Line 15, Column 6 or

Column 7.

Part IV - Calculation of Reimbursement Settlement

Line 16 = Enter sum of Lines 6 and 12. Column 8.

Line 17 - Enter total charges for Waiver Program (excluding Respite and Home Adaptation) from Paid Claims Listing.

Line 18 - Reimbursable Cost. Enter the lesser of Line 16 or Line 17.

Line 19 - Reimbursable Respite and Home Adaptation Cost. Enter the sum of Lines 14 and 15. Column 8.

Line 20 - Total Medicaid Cost. Sum of Lines 18 and 19.

Line 21 - Enter amount received from the Program for Waiver Program services from the Medicaid Paid Claim Listings.

Line 22 - Enter Continuing Income or TPL from the Medicaid Paid Claim Listings.

Line 23 - Enter Balance Due Program\Vendor (line 20 minus lines 21 and 22) . Indicate overpayments in parentheses ().